		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003103

Facility Name: Memorial Convalescent Center

Address: 4315 Memorial Drive (Number) Belleville (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: (618)233-7750 **Fax #** (618)257-6839

IDPA ID Number: 37-0635502-002

Date of Initial License for Current Owners: 03/01/1964

Type of Ownership:

- [x] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code ____

In the event there are further questions about this report, please contact:
Name: Valorie Comley **Telephone Number:** (618)257-5613

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Joe Lanius

(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,717		22,940	26,657	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,717		22,940	26,657	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.62%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/03/1964

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 108 and days of care provided 11,692

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	426,395	2,400		428,795		428,795	283,360	712,155			1
2	Food Purchase		296,737		296,737		296,737		296,737			2
3	Housekeeping	84,579	10,336		94,915		94,915	39,302	134,217			3
4	Laundry		70,927		70,927		70,927	55,375	126,302			4
5	Heat and Other Utilities			78,101	78,101	(1,753)	76,348		76,348			5
6	Maintenance	53,894	5,373		59,267		59,267	19,893	79,160			6
7	Other (specify):*											7
8	TOTAL General Services	564,868	385,773	78,101	1,028,742	(1,753)	1,026,989	397,930	1,424,919			8
	B. Health Care and Programs											
9	Medical Director					5,750	5,750		5,750			9
10	Nursing and Medical Records	2,602,272	276,179	20,670	2,899,121	1,415	2,900,536	70,533	2,971,069			10
10a	Therapy	476,350	14,734		491,084		491,084	321,612	812,696			10a
11	Activities	82,125	4,656		86,781		86,781		86,781			11
12	Social Services	67,070			67,070		67,070	96,848	163,918			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Disposable Diapers		33,282		33,282		33,282	(3,226)	30,056			15
16	TOTAL Health Care and Programs	3,227,817	328,851	20,670	3,577,338	7,165	3,584,503	485,767	4,070,270			16
	C. General Administration											
17	Administrative	21,069			21,069	(5,750)	15,319		15,319			17
18	Directors Fees											18
19	Professional Services			26,891	26,891		26,891		26,891			19
20	Dues, Fees, Subscriptions & Promotions			5,664	5,664		5,664		5,664			20
21	Clerical & General Office Expenses	56,545		9,895	66,440	68	66,508	450,770	517,278			21
22	Employee Benefits & Payroll Taxes			693,735	693,735		693,735	296,763	990,498			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,900	52,900		52,900		52,900			26
27	Other (specify):* Bad Debts			65,618	65,618		65,618	(65,618)				27
28	TOTAL General Administration	77,614		854,703	932,317	(5,682)	926,635	681,915	1,608,550			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,870,299	714,624	953,474	5,538,397	(270)	5,538,127	1,565,612	7,103,739			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Memorial Convalescent Center #0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			136,049	136,049		136,049	142,033	278,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			136,049	136,049		136,049	142,033	278,082			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	88,417	383,685		472,102		472,102	197,124	669,226			39
40	Barber and Beauty Shops					270	270		270			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,292	59,292		59,292		59,292			42
43	Other (specify):*	69,289	46,515	10,692	126,496		126,496	77,443	203,939			43
44	**TOTAL Special Cost Centers**	157,706	430,200	69,984	657,890	270	658,160	274,567	932,727			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,028,005	1,144,824	1,159,507	6,332,336		6,332,336	1,982,212	8,314,548			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,612)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(65,618)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,230)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,049,442		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,049,442		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,982,212		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			270	10	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 270		47

Memorial Convalescent Center

ID# 0003103

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	283,360	0	0	0	0	0	0	0	0	0	283,360	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	39,302	0	0	0	0	0	0	0	0	0	39,302	3
4	Laundry	0	55,375	0	0	0	0	0	0	0	0	0	55,375	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	19,893	0	0	0	0	0	0	0	0	0	19,893	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	397,930	0	0	0	0	0	0	0	0	0	397,930	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	70,533	0	0	0	0	0	0	0	0	0	70,533	10
10a	Therapy	0	321,612	0	0	0	0	0	0	0	0	0	321,612	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	96,848	0	0	0	0	0	0	0	0	0	96,848	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(3,226)	0	0	0	0	0	0	0	0	0	(3,226)	15
16	**TOTAL Health Care and Programs**	0	485,767	0	0	0	0	0	0	0	0	0	485,767	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	450,770	0	0	0	0	0	0	0	0	0	450,770	21
22	Employee Benefits & Payroll Taxes	0	296,763	0	0	0	0	0	0	0	0	0	296,763	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(65,618)	0	0	0	0	0	0	0	0	0	0	(65,618)	27
28	**TOTAL General Administration**	(65,618)	747,533	0	0	0	0	0	0	0	0	0	681,915	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(65,618)	1,631,230	0	0	0	0	0	0	0	0	0	1,565,612	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,612)	143,645	0	0	0	0	0	0	0	0	0	142,033	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,612)	143,645	0	0	0	0	0	0	0	0	0	142,033	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	197,124	0	0	0	0	0	0	0	0	0	197,124	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	77,443	0	0	0	0	0	0	0	0	0	77,443	43
44	**TOTAL Special Cost Centers**	0	274,567	0	0	0	0	0	0	0	0	0	274,567	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,230)	2,049,442	0	0	0	0	0	0	0	0	0	1,982,212	45

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Employee Benefits	$ 693,735	Memorial Hospital	0.00%	$ 990,498	$ 296,763	1
2	V	21	Administration	167,282			618,052	450,770	2
3	V	6	Maintenance	135,615			155,508	19,893	3
4	V	4	Laundry	70,927			126,302	55,375	4
5	V	3	Housekeeping	94,915			134,217	39,302	5
6	V	1	Dietary	725,532			1,008,892	283,360	6
7	V	15	Central	33,282			30,056	(3,226)	7
8	V	39	Pharmacy,Medical Supplies	472,102			669,226	197,124	8
9	V	43	Ancillary Services	126,496			203,939	77,443	9
10	V	12	Social Service	67,070			163,918	96,848	10
11	V	10	Medical Records	1,685			72,218	70,533	11
12	V	10a	Therapy	491,084			812,696	321,612	12
13	V	30	Depreciation	136,049			279,694	143,645	13
14	Total			$ 3,215,774			$ 5,265,216	$ * 2,049,442	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Emp Ben-Nursing & Med Dir	Salaries	74,318,455	2	$ 25,523,414	$ 610,238	2,681,134	$ 920,790	1
2	21	Patient Accounts	Revenue	394,406,580	2	2,743,744	1,064,213	3,949,854	27,478	2
3	21	Communications	Phones	1,211	2	494,245	189,641	6	2,449	3
4	21	Data Processing	Resources	10,000	2	2,244,490	759,504	70	15,711	4
5	21	Materials Management	Stores Requisitions	5,205,456	2	594,280	410,485	138,745	15,840	5
6	21	Administration	Accumulated Cost	151,029,941	2	20,575,018	4,220,187	4,085,504	556,574	6
7	6	Plant	Square Feet	18,453	2	178,025	53,897	16,119	155,508	7
8	4	Laundry	Pounds	2,304,242	2	1,023,761	379,986	284,275	126,302	8
9	3	Housekeeping	Hours of Service	109,664	2	2,492,999	1,381,631	45	1,023	9
10	3	Housekeeping MCC	Square Feet	17,705	2	146,299	84,579	16,119	133,194	10
11	1	Dietary	Patient Meals	251,072	2	3,167,454	1,577,442	79,971	1,008,892	11
12	22	Emp Ben-Cafeteria	Employee Meals	148,977	2	1,245,001	458,643	8,105	67,733	12
13	10	Medical Records	Time Spent	10,000	2	4,248,103	2,137,120	170	72,218	13
14	12	Social Service	Time Spent	1,388,370	2	803,454	463,483	283,250	163,918	14
15	43	Radiology	Revenue	87,510,113	2	10,978,840	3,213,565	244,118	30,627	15
16	43	Laboratory	Revenue	64,013,976	2	13,095,816	3,918,089	603,197	123,401	16
17	43	Nutritional Support	Revenue	901,171	2	522,627	205,832	64,013	37,124	17
18	43	EKG	Revenue	16,186,499	2	3,000,450	1,006,645	68,982	12,787	18
19	39	Drugs & IV Therapy	Revenue	34,240,443	2	10,728,861	2,073,632	1,660,528	520,308	19
20	39	Medical Supplies Sold	Revenue	3,156,272	2	4,588,387	597,508	123,113	178,974	20
21	10a	Respiratory Care	Revenue	21,388,326	2	3,584,906	1,820,073	360,233	60,379	21
22	10a	Physical Therapy	Revenue	16,703,127	2	5,845,289	2,906,342	1,606,171	562,082	22
23	10a	Occupational Therapy	Revenue	1,900,382	2	480,522	269,335	719,056	181,817	23
24	10a	Speech Therapy	Revenue	136,565	2	114,959	61,941	10,000	8,418	24
25	TOTALS					$ 118,420,944	$ 29,864,011		$ 4,983,547	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Capital Costs	See Attached	12,800,837		$ 12,800,837	$	279,694	$ 279,694	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 12,800,837	$		$ 279,694	25

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2				Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2004 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	**8**
	2001	**9**
	2002	**10**
	2003	**11**
	2004	**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Memorial Convalescent Center COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0003103

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,001 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1964	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	108		1964	1964	$ 882,395	$ 1,404		$	$ (1,404)	$ 882,395	4
5			1966		144,150	314			(314)	144,150	5
6			1979		237,657	1,581	20.28	1,581		222,480	6
7			1980		2,695					2,695	7
8			1981		18,583					18,583	8
	Improvement Type**										
9	Electrical Upgrade			1996	25,549	1,356		1,356		12,911	9
10	Walking Track			1998	7,690	513	15	513		3,847	10
11	Roof Replacement			1998	68,383	6,839	10	6,839		51,287	11
12	Change in electical power system			1998	5,479	365	15	365		2,738	12
13	7 1/2 ton A/C Unit			1998	14,326	955	15	955		7,163	13
14	Air furnace			1998	15,226	1,015	15	1,015		7,613	14
15	5 ton air handler			1998	14,900	994	15	994		7,449	15
16	Electrical work-boiler rm, A/C unit, relamp, auto tr switch			1998	91,162	4,558	20	4,558		34,183	16
17	Air handling unit installed			1994	12,048	804	15	804		9,236	17
18	Repair parking lot			1994	83,569	2,782	10.85	2,782		71,357	18
19	Landscaping			1994	4,200	280	15	280		3,220	19
20	Flooring replaced patient room			1993	56,883	3,793	15	3,793		47,405	20
21	Activity Therapy Renovation			1993	41,940	2,264	12.83	2,264		33,332	21
22	Condensing unit			1993	4,684	313	15	313		3,903	22
23	Air conditioners			1993	6,589	439	15	439		5,490	23
24	Upgrade lighting			1993	4,516	226	20	226		2,825	24
25	Renovate patient room & nurse station			1992	42,370	2,324	17.99	2,324		31,674	25
26	Renovate patient rooms-doors, wallcovering,bldg			1992	75,908	723	10.49	723		74,827	26
27	Roof top air conditioner			1992	4,342	290	15	290		3,908	27
28	Renovate business office			1991	35,387	1,818	18.5	1,818		29,192	28
29	Patient rooms-drywall,ceiling, paint			1991	39,835	2,424	14.55	2,424		38,125	29
30	Demolish back lounge			1991	752	51	15	51		727	30
31	Brickwork chimney			1991	5,225	349	15	349		5,051	31
32	Paint exterior tower			1991	1,185		5			1,185	32
33	ITE panel			1991	995	50	20	50		723	33
34	Air conditioners			1991	6,580	439	15	439		6,361	34
35	Telephone wiring			1991	924		10			924	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Circuit Breaker	1991	$ 1,011	$ 50	20	$ 50	$	$ 733	37
38	Cubicles & track	1990	9,899		5			9,899	38
39	Half glass door windows	1989	601		15			601	39
40	Roofing	1988	55,463		10			55,463	40
41	Air Conditioner	1998	1,556		5			1,556	41
42	Air Conditioner	1987	1,551		5			1,551	42
43	Remove bathroom showers	1987	17,966	462	15.56	462		17,271	43
44	Cooling units	1986	3,854		9			3,854	44
45	Cooling units	1985	5,644		10			5,644	45
46	Resurface road	1985	39,780		12			39,780	46
47	Guttering	1985	2,116		15			2,116	47
48	Metal door frames	1984	5,751		20			5,751	48
49	Water & sewer lines	1984	2,807		20			2,807	49
50	Sprinkler system	1978	27,578		19			27,578	50
51	Sprinkler system	1977	1,585		20			1,585	51
52	Cooling unit & heat detectors	1974	5,468		17.99			5,468	52
53	Air conditioners & beauty shop	1973	1,210		14.94			1,210	53
54	Heating & cooling equipment	1972	53,944		15.22			53,944	54
55	Smoke detector	1971	5,800		10			5,800	55
56	Land improvements	1968	4,238		40	106	106	4,187	56
57	Vinyl flooring restrooms	1999	2,441		5			2,441	57
58	Reznor make up air unit	1999	15,432	1,543	10	1,543		10,030	58
59	Electrical work	1999	2,566	128	20	128		832	59
60	New door physical therapy	2000	3,735	249	15	249		1,370	60
61	Porch columns	2000	5,965	398	15	398		2,189	61
62	Repair walls	2001	2,080	139	15	139		625	62
63	Electrical work	2001	4,191	210	20	210		944	63
64	Electrical work	2001	16,778	839	20	839		3,775	64
65	Window replacement	2002	113,345	7,557	15	7,557		26,449	65
66	Storage addition	2002	253,195	16,880	15	16,880		59,081	66
67	Storage addition	2002	4,227	846	5	846		2,959	67
68	Storage addition	2002	1,259		1			1,259	68
69	Fire Alarm/Nurse Call Replacement	2002	4,473	299	15	299		1,046	69
70	TOTAL (lines 4 thru 69)		$ 2,633,636	$ 68,863		$ 67,251	$ (1,612)	$ 2,126,757	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,633,636	$ 68,863		$ 67,251	$ (1,612)	$ 2,126,757	1
2	Fire Alarm/Nurse Call Replacement	2002	350	58	3	58		350	2
3	Fire Alarm/Nurse Call Replacement	2002	1,001	200	5	200		700	3
4	Fire Alarm/Nurse Call Replacement	2002	48,125	4,812	10	4,812		16,843	4
5	Fire Alarm/Nurse Call Replacement	2002	490	33	15	33		115	5
6	Fire Alarm/Nurse Call Replacement	2002	61,775	3,088	20	3,088		10,808	6
7	Patient Wardrobe Units	2002	67,813	4,521	15	4,521		15,824	7
8	Patient Wardrobe Units	2002	5,824	583	10	583		2,038	8
9	Heating and Cooling Unit	2002	7,702	514	15	514		1,797	9
10	8" Faucets	2002	5,318	266	20	266		931	10
11	Window Replacement	2003	75	5	15	5		13	11
12	Storage Addition	2003	138	9	15	9		23	12
13	Fire Alarm/Nurse Call Replacement	2003	659	66	10	66		165	13
14	Window Replacement	2003	16,451	1,097	15	1,097		2,742	14
15	Patient Wardrobe Units	2003	16,789	839	20	839		2,098	15
16	Fire Alarm/Nurse Call Replacement	2003	19,745	987	20	987		2,468	16
17	Utility Storage Room Plumbing Work	2004	776	38	20	38		58	17
18	Beauty Shop/Utility Room Renovations	2004	4,626	231	20	231		347	18
19	Roof	2005	4,910	123	20	123		123	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,896,203	$ 86,333		$ 84,721	$ (1,612)	$ 2,184,200	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 381,438	$ 47,936	$ 47,936	$		$ 218,906	71
72	Current Year Purchases	21,536	1,780	1,780		6.25	1,780	72
73	Fully Depreciated Assets	202,876					202,876	73
74								74
75	TOTALS	$ 605,850	$ 49,716	$ 49,716	$		$ 423,562	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		2000 Ford Bus	2000	$ 49,174	$	$	$	4	$ 49,174	76
77										77
78										78
79										79
80	TOTALS			$ 49,174	$	$	$		$ 49,174	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,591,227	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 136,049	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,437	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,612)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,656,936	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 80,722 Description: See page 24
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a	hrs	$ 146,756		$	$ 3,065		$ 149,821	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs	294,411			3,953		298,364	4
5	Physician Care	10	visits		33	8,255		33	8,255	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts	88,417			383,685		472,102	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 529,584	33	$ 8,255	$ 390,703	33	$ 928,542	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Memorial Convalescent Center **#** 0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 325	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	841,584		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,302		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due third-party payers	6,152		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 856,363	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,771,270		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	646,725		16
17	Accumulated Depreciation (book methods)	(2,657,409)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	152,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 952,875	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,809,238	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 109,936	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,097		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 279,033	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserves for Self Insurance	457,996		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 457,996	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 737,029	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,072,209	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,809,238	$	48

***(See instructions.)**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 989,161	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 989,161	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(51,803)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (51,803)	17	
	B. Transfers (Itemize):			
18	**Interfund Transfer - Hospital**	134,851	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 134,851	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,072,209	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,949,854	1
2	Discounts and Allowances for all Levels	(3,151,261)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 798,593	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,335,228	6
7	Oxygen	360,233	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,695,461	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	270	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,660,528	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	603,197	19
20	Radiology and X-Ray	244,118	20
21	Other Medical Services	256,108	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,764,221	23
	D. Non-Operating Revenue		
24	Contributions	22,258	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,258	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,280,533	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,028,742	31
32	Health Care	3,577,338	32
33	General Administration	932,317	33
	B. Capital Expense		
34	Ownership	136,049	34
	C. Ancillary Expense		
35	Special Cost Centers	598,598	35
36	Provider Participation Fee	59,292	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,332,336	40
41	**Income before Income Taxes (line 30 minus line 40)****	(51,803)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (51,803)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,505	2,012	$ 78,214	$ 38.87	1
2	Assistant Director of Nursing	1,918	2,237	70,752	31.63	2
3	Registered Nurses	28,766	32,702	853,227	26.09	3
4	Licensed Practical Nurses	11,926	13,106	267,116	20.38	4
5	CNAs & Orderlies	73,244	82,603	1,029,530	12.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,725	5,440	82,125	15.10	10
11	Social Service Workers	2,846	3,203	67,070	20.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	34,665	39,929	426,395	10.68	15
16	Dishwashers					16
17	Maintenance Workers	3,074	3,528	53,894	15.28	17
18	Housekeepers	7,553	8,500	84,579	9.95	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	222	253	15,319	60.55	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,014	20,659	358,292	17.34	24
25	Vocational Instruction	6,126	6,926	146,756	21.19	25
26	Academic Instruction					26
27	Medical Director	98	107	5,750	53.74	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	107	119	1,685	14.16	31
32	Other Health Care(specify)	20,243	23,185	487,301	21.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,032	244,509	$ 4,028,005 *	$ 16.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Physician Advisor	57	7,200	Ln 10 Col 3	46
47			5,216	Ln 10 Col 3	47
48					48
49	TOTAL (lines 35 - 48)	57	$ 12,416		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	257	4,949	Ln 10 Col 1	52
53	TOTAL (lines 50 - 52)	257	$ 4,949		53

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joe Lanius	VP - Fianance		$ 6,740
Terry Walther	VP - Rehab		8,579
Dr. William Sutherland	Medical Director		5,750
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 21,069

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bell, Boyd & Lloyd, PLLC	Attorney Fees	$ 22,591
B.K.D., LLP	Audit Fees	4,300
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 26,891

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Illinois Health Care	5,664
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,664

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Memorial Convalescent Center # 0003103 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Memorial Convalescent Center # 0003103 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care $5,664**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.25**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,056** Line **15**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,292**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **67,734** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,097,301**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BKD, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.